



## Prior Authorization Form



Prior Authorization Services:	
<input type="checkbox"/>	Inpatient Detoxification
<input type="checkbox"/>	Medication Assisted Treatment (OTP Bundle) Monthly PA
<input type="checkbox"/>	Medication Exceeding \$500 Maximum
<input type="checkbox"/>	Other

<p>Please provide a narrative about this participant. Ensure that you address the following questions:</p> <ul style="list-style-type: none"><li>• What distinctive characteristics make this participant a good candidate for the recommended services?</li><li>• What resources have you already utilized to assist the participant?</li><li>• What plan is in place to address the participant's recovery needs in the future? (if asking for additional resources)</li><li>• How will action on this affect the participant's recovery?</li><li>• What plan is in place to get the participant Insurance Coverage, either public or private?</li></ul>
<p>Narrative:</p>

FOR OFFICE USE ONLY	
<input type="checkbox"/> Approved	<input type="checkbox"/> Rejected                 Date Rv'd: _____
Approved by:	
Amount or Services Approved:	
Determination Date:	